A healthy approach to quality and care in 2013

We at Altron Medical Aid work hard on our promise to give you the best of care at all times. In delivering on this promise, we always need to balance the cost of healthcare with the benefits we provide to make sure that, as a member of the Altron Medical Aid, you continue to enjoy the best of care in 2013.

This year, Altron Medical Aid continues to work hard to make sure the care and services you receive make a significant difference in your life and are relevant to your individual needs.

Please read through your brochure and visit the website to see what we have in store for you in 2013.
Where to contact us

Service Centre ........................................ 0860 222 999

On the web ............................................. www.altronmedicalaid.co.za

Emergency .............................................. Discovery 911 on 0860 999 911
  24 hours a day, seven days a week

Benefit queries ................................. service@discovery.co.za

Oncology and HIVCare Programmes........................................ 0860 100 417

Diabetes Programme ......................... 011 712 6000

Smart Health Choices ................. 0860 999 911
  smarthealth@discovery.co.za

Vitality queries ................................. vitalityinfo@discovery.co.za

DiscoveryCard queries ............... 0860 112 273

Officers of the Scheme
Your employer trustees are:

Alex Smith
Neil Kayton
Chris Potgieter
Dr John Carstens

Your employee trustees are:

Peter Mason
Philip Crow
Graham Passmoor
Ann O’Connell

Principal Officer of the Scheme:
Roger Sedlmaier
Why Altron Medical Aid is so competitive

1. We have two Options that meet your needs
   We offer two different Options to meet your healthcare needs.

2. Our contributions are affordable and sustainable
   Altron Medical Aid’s Options are priced to be competitive and offer excellent value for money.

3. You’ll have medical cover no matter where you are
   Locally, the Discovery Medicopters that operate from Johannesburg, Cape Town and Durban make sure our members get medical support and are air-lifted in critical cases.

4. We give you access to advanced medicine and technology
   We review your application individually to make sure that your needs are met, because Altron Medical Aid members can get cover for innovative medical technology and expensive medicine. For example, our members have some of the best cancer benefits available in the healthcare insurance market.

5. We give you control over your daily medical expenses
   With the help of a Medical Savings Account, you can make informed choices about how much you spend on day-to-day healthcare. Unused funds are carried over to the next year, unlike traditional options where unused funds are lost.

6. You can benefit from early detection
   A range of preventive healthcare services form part of the Screening and Prevention Benefit to help you stay healthy. If your Medical Savings Account runs out of funds, we extend our cover with the Insured Network Benefit:
   - For members on the Enhanced Option, this covers GP consultation fees at a GP in the Discovery Health GP network. We also cover pathology tests at our network providers if they are requested with the Discovery Health pathology form.
   - For members on the Basic Option, we cover two consultations per year for a single member and four consultations per year for a family.

7. You can make the Full Cover Choice
   The scale of our administrator, Discovery Health, allows you to benefit from the agreements they have set in place with hospitals, GPs, specialists and other healthcare service providers. Whenever you choose to use one of the providers in the Discovery Health network, you choose full cover.

   Both our Options have a defined list of medicine for chronic conditions. You can get access to full cover for chronic medicine by choosing your chronic medicine from the list.

8. Vitality gives you the tools for a healthier you
   As an Altron Medical Aid member, you can become healthier by joining Vitality, Discovery’s science-based programme with its personalised approach to wellness. Vitality membership is optional.
We always have your health in mind

**New members**
When you become an Altron Medical Aid member, your membership will start on your first day of duty at the Altron Group. If you resign, your Altron Medical Aid membership will end on the last day of the month in which you resign from the Altron Group. Medical scheme contributions are always deducted for a full month, even if you are not employed for a full month.

**Current members**
As an Altron Group pension or disability scheme member, you are entitled to stay a member of the Altron Medical Aid when you retire or draw disability benefits, subject to the Scheme’s rules. In the event of your death, your spouse will be entitled to continue membership to the Scheme. If you have child dependants, they are also entitled to membership for as long as they are eligible according to the Scheme’s rules.

**Your dependants**
For membership of the Altron Medical Scheme, dependants are usually direct family members for whom you are legally responsible. An adult dependant is a spouse, a qualifying partner or a child over the age of 21 who is a full-time student.

An adult dependant could also be any other blood relative who is financially dependent on you. Such a person is a “special dependant”, and you must apply if you want us to consider your special dependant for membership, as we do not automatically cover special dependants. Please talk to your HR manager or visit our website at www.altronmedicalaid.co.za for details on how to apply.

Important information about your hospital cover

In an emergency, go straight to hospital but call us (or let someone call us) within 24 hours.

If you know you are going to hospital for a planned procedure, call us on 0860 222 999 to get authorisation for your hospital admission at least 72 hours before going. If you do not confirm your admission, we may only pay 90% of the cost that we would normally cover and you will have to pay the rest.

**Your cover is subject to our rules**
We pay claims when they are medically appropriate, meaning the treatment fits the diagnosis. Your cover is subject to the Scheme’s rules, funding guidelines and clinical rules.

While you are in hospital, there are some expenses that your benefit does not cover, like private ward costs. For these you would have to pay yourself.

Certain procedures, medicines or new technologies need separate confirmation while you are in hospital. Call us (or let someone call us) on 0860 222 999 to get authorisation for these.

**Your cover in a medical emergency**
A medical emergency is when you suddenly and unexpectedly need medical or surgical treatment for a health condition that could lead to serious loss of body function, damage to organs or even death if you do not get immediate medical attention.

**Cover for medical emergencies in South Africa**
In a medical emergency, call Discovery 911 on 0860 999 911 – this number is on your membership card and car sticker for easy reference. If you need to go to hospital in an ambulance or helicopter, we will cover these costs from your Trauma Benefit if you use one of our preferred providers.

**You are covered outside South Africa’s borders**
If you have to pay the bills for a medical emergency while visiting an SADC (Southern African Development Community) country, we will refund you at Scheme Rates as set out in the Scheme’s rules, up to the limits for the specific benefits. Please also read the Scheme exclusions before you travel.

Costs for medical emergencies in countries outside the SADC countries are limited to a yearly amount of R1 900 for the family. This applies to the Trauma Benefit and Acute Benefits as set out in the table of benefits. We do not cover costs that are not for life-threatening conditions and of a medical nature.

**Casualty visits and consultations**
If you are admitted to hospital from casualty, the claims will be funded from your Trauma Benefit. If you are not admitted to hospital, the claims will be funded from your Acute Benefit and will be subject to available funds.
Our GP network

Altron Medical Aid is a participant in the Discovery Health GP Network. If you consult with a GP in the Discovery Health GP Network, you will enjoy full cover.

Please visit our website at www.altronmedicalaid.co.za and log in to find your nearest participating GP.

On the Basic Option

- In Phase 1, we cover the GP’s consultation code in full.
- Once Phase 1 is depleted, we pay the GP’s consultation code in full, for up to two consultations for a single member and four consultations per family at a network GP.

On the Enhanced Option

- In Phase 1, we cover the GP’s consultation code in full.
- If you enter Phase 2, we still pay the GP’s consultation code in full as long as you use a network GP.
- Altron Medical Aid fully covers certain pathology tests requested by a Discovery Health network GP if the GP uses the Discovery Health Pathology Form to request these tests. If you do not use a network GP or the Discovery Health Pathology form and you are in a self-funding phase, your pathology claims will not be paid by the Scheme.

Our specialist network

Altron Medical Aid gives you access to the Discovery Health Premier and Classic Direct Payment Arrangements. The Basic Option will only have access to the Premier Direct Payment Arrangement but the Enhanced Option will have access to both. You benefit most when you use healthcare professionals who participate in these payment arrangements, because Altron Medical Aid will cover the cost of their approved procedures in full.

Healthcare professionals who participate in the payment arrangements are also our Designated Service Providers for the Prescribed Minimum Benefits.

Please visit our website at www.altronmedicalaid.co.za and log in to find your nearest participating specialist.

Screening and Prevention Benefit covered on both Options

The Screening and Prevention Benefit covers a group of tests up to a maximum of R135 at network pharmacies. The group of tests, which is called the Vitality Check, includes the following:

- Blood glucose
- Blood pressure
- Cholesterol
- Body mass index (BMI) or weight assessment.

Related consultations and costs will be paid from the relevant phase. You can have one Vitality Check a year at a pharmacy in the Discovery Wellness Network.

We also cover a mammogram, Pap smear, PSA (a prostate screening test) and HIV screening tests. Members registered for certain chronic conditions, as well as members over the age of 65, can have a seasonal flu vaccine every year and save.
Helping you get the most out of your cover

On all Altron Medical Aid’s Options, you have the opportunity to get full cover for hospitalisation and chronic medicine.

We have a range of online tools and advisors available to help guide you to the Full Cover Choice. This way, you won’t be faced with co-payments when using healthcare services or gaps in cover when it’s time to claim.

When you need to go to the doctor
MaPS Advisor

This Medical and Provider Search Advisor helps you find a healthcare professional in the Discovery Health networks. These healthcare professionals have agreed to only charge the Scheme Rate and we will pay them in full.

When you’re at the doctor
HealthID

HealthID, is an iPad application developed by our administrator, Discovery Health. It is intended for use by healthcare professionals, and is the first of its kind in South Africa. Soon, many doctors will be able to access your health records via an iPad. Access to your health record will only take place with your consent.

When you need medicine
Discovery MedXpress

This convenient medicine delivery service delivers your medicine to your door. By following a few easy steps, you will no longer need to go to a pharmacy to collect your medicine. What’s more, you will pay no delivery or administration fees and our service agents can give you advice about the most cost-effective generics. You will always be charged at the Scheme Rate or less, which lessens the possibility of a co-payment.

1. Send us your script
Mark it “Discovery MedXpress” and email it to medxpress@discovery.co.za

2. Call us on 0860 222 999 to place your order
We’ll keep you updated about the progress of your order via SMS.

3. We deliver your medicine to you
Summary of Altron Medical Aid’s benefits for 2013

Trauma Benefit

The Trauma Benefit covers hospitalisation in a general ward and related in-hospital accounts (like those from your specialist and anaesthetist). We cover these expenses at 100% of the Scheme Rate, provided that Altron Medical Aid has authorised the treatment. Payment from the Trauma Benefit is not subject to an overall limit, although certain sub-limits do apply.

Altron Medical Aid uses the Discovery Health Rate as its Scheme Rate.

Casualty claims are not paid from the Trauma Benefit. The exception is when you are admitted to hospital after being treated in a casualty ward and you have an authorisation number for hospitalisation.

Chronic Illness Benefit

The Chronic Illness Benefit covers approved medicines for 27 chronic conditions, including HIV and AIDS. We will pay your approved chronic medicine in full if it is on the Altron Medical Aid’s medicine list (formulary). If your approved chronic medicine is not on our list, we will pay your chronic medicine up to a set monthly amount (Chronic Drug Amount).

You must apply for chronic cover by completing a chronic application form with your doctor and submitting it for review.

Please note:
Admission to a private ward will be for your own pocket.

The conditions covered under the Chronic Illness Benefit on both Options

An extensive list of Chronic Illness Benefit conditions is covered on both Options. The cover for chronic medicine is subject to formularies and reference pricing.

- Addison’s disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease (COPD)
- Chronic renal disease
- Coronary artery disease
- Crohn’s disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- HIV and AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson’s disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis
- Acne
- Attention deficit hyperactivity disorder (ADHD) in children
- Allergic rhinitis
- Benign prostatic hypertrophy
- Cancer
- Chronic depression
- Chronic hepatitis
- Cystic fibrosis
- Gastro-oesophageal reflux disease (GORD)
- Gout
- Hormone replacement therapy
- Hypo-parathyroidism
- Motor neurone disease
- Obsessive compulsive disorder
- Organ transplant
- Osteoarthritis
- Osteoporosis
- Paget’s disease
- Pituitary Adenoma
- Psoriasis

The additional chronic disease list for members on the Enhanced Option

Members on the Enhanced Option have access to additional cover for certain conditions, as approved by the Trustees from time to time.

- Acne
  Script required from endocrinologist or dermatologist
- Attention deficit hyperactivity disorder (ADHD) in children
- Allergic rhinitis
- Benign prostatic hypertrophy
- Cancer
- Chronic depression
- Chronic hepatitis
- Cystic fibrosis
- Gastro-oesophageal reflux disease (GORD)
- Gout
- Hormone replacement therapy
- Hypo-parathyroidism
- Motor neurone disease
- Obsessive compulsive disorder
- Organ transplant
- Osteoarthritis
- Osteoporosis
- Paget’s disease
- Pituitary Adenoma
- Psoriasis

Chronic conditions not covered by the Chronic Illness Benefit will be paid from your Acute Benefit (day-to-day benefits), depending on the phase you are in at the time. This is subject to the Scheme rules and available funds.
The Prescribed Minimum Benefits

What is a Prescribed Minimum Benefit?

Prescribed Minimum Benefits are prescribed by law. They make up the minimum benefit package that any member of any medical scheme member is entitled to. The Council for Medical Scheme’s regulations state that medical schemes have to provide cover for certain conditions at Designated Service Providers – even when scheme exclusions, waiting periods or limits apply.

What we cover as a Prescribed Minimum Benefit

We cover the diagnosis, consultations and medicine for chronic conditions (including HIV and AIDS) according to the Prescribed Minimum Benefit treatment guidelines. The Chronic Illness Benefit covers a limited number of diagnostic tests and consultations for these conditions. The benefit includes tests and consultations for the diagnosis and management of each condition.

How claims under the Prescribed Minimum Benefit are paid

Your cover depends on whether you choose to use Altron Medical Aid’s Designated Service Providers. Altron Medical Aid has selected specific hospital networks and other service providers to be the designated providers of healthcare services to our members. We also have contracts with specific State facilities.

If you choose to use Altron Medical Aid’s Designated Service Providers, we pay your medical expenses in full from your Trauma Benefit. If you choose to use a provider that is not one of our Designated Service Providers, we will pay up to the Scheme Rate for your medical expenses while you are in hospital.

The latest list of hospitals and other service providers is available on www.altronmedicalaid.co.za

Admittance to hospital in an emergency is always covered

If you are in a medical emergency and the emergency services admit you to a hospital that is not part of the Altron Medical Aid’s Designated Service Providers, you will be transferred to a State or DSP hospital as soon as soon as you are stable enough to be transferred, or when a bed becomes available.

However, if you do not want to move to a State or Designated Service Provider hospital, we will only pay for your medical expenses up to the Scheme Rate from the date that you chose to stay in a hospital that is not part of Altron Medical Aid’s Designated Service Providers.

Remember, you always have to get authorisation for hospital admission. We will only pay your in-hospital expenses if your admittance is approved.

Acute Benefit

The amount that is available in your Savings Account on your Acute Benefit during Phase 1 is calculated based on 20% of your total yearly contribution for yourself and your dependants.

Enhanced Option

Phase 1
Your Savings Account equals 20% of your annual contribution. We cover you at the Scheme Rate.

Phase 2
You pay day-to-day medical expenses from your own pocket, but send us the accounts so that we can record costs at the Scheme Rate. Once expenses add up to 15% of your annual contribution, you enter Phase 3.

Phase 3
We pay your day-to-day medical expenses at the Scheme Rate, up to certain limits. When expenses add up to 45% of your annual contribution, you enter Phase 4.

Phase 4
This phase is unlimited. We pay your day-to-day medical expenses at 60% of the Scheme Rate, and you pay the rest. Certain limits apply.

Basic Option

Phase 1
Your Savings Account equals 20% of your annual contribution. We cover you at the Scheme Rate.

Afterwards
After your Savings Account has been depleted, you have to pay your day-to-day medical expenses from your own pocket.

Trauma Benefit

Cover for emergency and planned hospital stays

If you are in a medical emergency and the emergency services admit you to a hospital that is not part of the Altron Medical Aid’s Designated Service Providers, you will be transferred to a State or DSP hospital as soon as soon as you are stable enough to be transferred, or when a bed becomes available.

However, if you do not want to move to a State or Designated Service Provider hospital, we will only pay for your medical expenses up to the Scheme Rate from the date that you chose to stay in a hospital that is not part of Altron Medical Aid’s Designated Service Providers.

Remember, you always have to get authorisation for hospital admission. We will only pay your in-hospital expenses if your admittance is approved.
The Basic Option’s Acute Benefit

The Basic Option funds out-of-hospital medical expenses, like accounts from general practitioners and dentists, from the Acute Benefit (for day-to-day medical expenses). During Phase 1, these expenses are covered from your Savings Account. Once you have depleted your Savings Account, you have to pay for daily medical expenses yourself.

Your acute medical expenses are funded from your Savings Account. The amount in your Savings Account is calculated based on 20% of the total yearly contribution for you and your dependants. Any remaining funds are carried over to the following year.

Use a network GP to get the most from your Acute Benefit

To get full cover for GP consultations, you can use the Discovery Health GP Network. If your Savings Account is depleted, you can still visit a network GP, because the Scheme pays for GP consultations up to a certain limit after your Savings Account has been depleted. The maximum number of consultations we cover after Phase 1 for a single member or family each year is:

- Two consultations for a single member
- Four consultations for a family.

You can also use the Discovery Health Premier Specialist Network for your consultations and procedures with specialists to avoid any co-payments. Please refer to page 3 of this guide for more details about this network.

Please visit www.altronmedicalaid.co.za and log in to find your nearest GP or specialist who participates in Discovery Health’s networks.
The Enhanced Option's Acute Benefit

The Enhanced Option funds out-of-hospital medical expenses, like accounts from general practitioners and dentists, from the Acute Benefit (for day-to-day medical expenses). The Acute Benefit pays your claims at the Scheme Rate. The Acute Benefit on the Enhanced Option has four stages, from Phase 1 to Phase 4, all subject to available funds and limits.

- **Phase 1**: Your daily medical expenses are covered from your Savings Account. The amount in your Savings Account is calculated based on 20% of your total yearly contribution for yourself and your dependants. Any funds left for the year are carried over to the following year, once the four-month run-off period has ended.

- **Phase 2**: You pay day-to-day medical expenses from your own pocket, but send us the accounts so that we can record costs at the Scheme Rate. Once expenses add up to 15% of your annual contribution, you enter Phase 3.

- **Phase 3**: We pay your day-to-day medical expenses at the Scheme Rate, up to certain limits. When expenses add up to 45% of your annual contribution, you enter Phase 4.

- **Phase 4**: This phase is unlimited. We pay your day-to-day medical expenses at 60% of the Scheme Rate, and you pay the rest. Certain limits apply.

Use a network GP to get the most from your Acute Benefit

To get full cover for GP consultations, you can use the Discovery Health GP Network. If your Savings Account is depleted, you can still visit a network GP, because the Scheme pays the GP directly for consultations after your Savings Account has been depleted. There is no limit for visits to Network GPs on the Enhanced Option.

You can also use the Discovery Health Premier Specialist Network and Classic Direct Network for your consultations and procedures with specialists to avoid any co-payments. Please refer to page 3 of this guide for more details about this network.

Please visit www.altronmedicalaid.co.za and log in to find your nearest GP or specialist who participates in Discovery Health's networks.

Accumulation values through Phase 2 to reach Phase 3

<table>
<thead>
<tr>
<th>Family size</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main member</td>
<td>R10 803</td>
</tr>
<tr>
<td>Adult dependant</td>
<td>R9 123</td>
</tr>
<tr>
<td>Child dependant</td>
<td>R1 718</td>
</tr>
</tbody>
</table>
## Benefit Schedule

All limits apply to the whole family, unless otherwise indicated.

### Some limits are pro-rated

Dentistry, optical benefits and all other benefits with limits are pro-rated according to the number of months left in the calendar year when you join the Scheme.

## Hospital and related costs

Private and State hospitals are covered at 100% of the Scheme Rate, unless otherwise specified.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Benefit category</th>
<th>Requirements</th>
<th>Basic Option</th>
<th>Enhanced Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>Ambulance services</td>
<td></td>
<td>- R3 800 per event if you do not use our preferred provider network</td>
<td></td>
</tr>
<tr>
<td>Hospital and related services</td>
<td>- You will have to pay 10% of the hospital account if you do not get authorisation</td>
<td></td>
<td>- Unlimited, paid at 100% of the Scheme Rate</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and confinement</td>
<td>- Authorisation required</td>
<td></td>
<td>- Unlimited, paid at 100% of the Scheme Rate</td>
<td></td>
</tr>
<tr>
<td>Organ transplants and renal dialysis</td>
<td>- Authorisation required</td>
<td></td>
<td>- Unlimited, paid at 100% of the Scheme Rate</td>
<td></td>
</tr>
<tr>
<td>Sterilisation</td>
<td>- Authorisation required</td>
<td></td>
<td>- R12 750 for each family for the year</td>
<td></td>
</tr>
<tr>
<td>Ending a pregnancy</td>
<td></td>
<td></td>
<td>- R1 500 co-payment for all sterilisation procedures if done under general anaesthetic</td>
<td></td>
</tr>
<tr>
<td>Oncology and radiotherapy</td>
<td>- Authorisation required</td>
<td>R340 000 for each family in a rolling 12-month period</td>
<td>- R400 000 for each family in a rolling 12-month period</td>
<td></td>
</tr>
<tr>
<td>Surgically implanted prosthetics</td>
<td>- Authorisation required</td>
<td>- Clinical entry criteria applies</td>
<td>- R63 400 for each family for the year</td>
<td>- R63 400 for each family for the year</td>
</tr>
<tr>
<td>Spinal prostheses and/or devices*</td>
<td>- Authorisation required</td>
<td></td>
<td>- R23 000 for the first level in respect of prostheses and/or devices</td>
<td></td>
</tr>
<tr>
<td>Hip joint, knee joint and shoulder joint prostheses</td>
<td>- Authorisation required</td>
<td></td>
<td>- R33 000 limit per prosthesis per admission if prosthesis is not supplied by the Scheme’s network provider</td>
<td></td>
</tr>
<tr>
<td>Psychiatric treatment</td>
<td>Includes hospitalisation, consultations, therapy and all related accounts while in hospital</td>
<td>Authorisation required for in-hospital treatment</td>
<td>21 days for in-hospital treatment for each person for the year</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>- Authorisation required</td>
<td></td>
<td>10 days for each family for the year</td>
<td></td>
</tr>
<tr>
<td>Home oxygen</td>
<td>- Authorisation required</td>
<td></td>
<td>- R650 per beneficiary per month</td>
<td>Designated Service Provider – Vitalaire</td>
</tr>
</tbody>
</table>

*Conservative back treatment is subject to meeting clinical entry criteria and receiving authorisation. Admission to hospital without the necessary authorisation will result in a member co-payment of 30% of the total cost of the event.*
## Diagnostic procedures

<table>
<thead>
<tr>
<th>Classification</th>
<th>Benefit category</th>
<th>Requirements</th>
<th>Basic Option</th>
<th>Enhanced Option</th>
</tr>
</thead>
</table>
| **Trauma**    | **Radiology or pathology in hospital** | - Authorisation required  
- PET, MRI and CT scans require specialist referral | - Unlimited 100% of Scheme Rate  
- PET scans not covered  
**MRI/CT scans**  
- R2 450 co-payment payable by member per scan, regardless of whether scan is performed in hospital or out of hospital | - Unlimited 100% of Scheme Rate  
**MRI/CT scans**  
- R2 450 co-payment payable by member per scan regardless of whether scan is performed in hospital or out of hospital |
| **Endoscopies** | - Gastroscopy  
- Sigmoidoscopy  
- Proctoscopy  
- Colonoscopy | - Subject to preauthorisation | **In hospital**  
- First R2 850 of the hospital account paid from Phase 1  
- Balance of hospital account paid by the Scheme  
**Out of hospital**  
- No co-payment applies. All claims are paid by the Scheme up to the Scheme Rate | **In hospital**  
- First R2 300 of the hospital account paid from the relevant phase  
- Balance of hospital account paid by the Scheme  
**Out of hospital**  
- No co-payment applies. All claims are paid by the Scheme up to the Scheme Rate |
| **Laparoscopic surgery** | - Subject to preauthorisation | Subject to a deductible of R2 300 on all laparoscopies, except:  
- Aspiration/excision of ovarian cyst  
- Laparoscopic cholecystectomy  
- Laparoscopic appendectomy for females  
- Repair of recurrent or bilateral inguinal hernias | Subject to the cover available in Phase 1  
- Basic radiology, excluding MRI/CT scans  
- Subject to the cover available in phase you are in | Subject to the cover available in phase you are in |
| **Acute**     | **Radiology out of hospital** | - Basic radiology, excluding MRI/CT scans  
- Subject to the cover available in Phase 1 | - Basic radiology, excluding MRI/CT scans  
- Subject to the cover available in phase you are in | - Basic radiology, excluding MRI/CT scans  
- Subject to the cover available in phase you are in |
|               | **Pathology out of hospital** | - The network GP has to request pathology tests on the Discovery Health pathology form  
- Subject to the cover available in Phase 1  
- Paid in full even when Phase 1 is exhausted | - Subject to the cover available in phase you are in  
- Paid in full even when in Phase 2 | - Subject to the cover available in phase you are in  
- Paid in full even when in Phase 2 |
### Dentistry*

<table>
<thead>
<tr>
<th>Classification</th>
<th>Benefit category</th>
<th>Requirements</th>
<th>Basic Option</th>
<th>Enhanced Option</th>
</tr>
</thead>
</table>
| **Trauma**     | *Dental hospitalisation for:*  
- Life-threatening infections  
- Internal temporomandibular joint surgical procedures  
- Cancer-related surgery  
- Severe trauma surgery  
- Cleft palate repair  
- Impacted wisdom teeth | - Authorisation required | - Unlimited 100% of Scheme Rate  
- Deductibles do not apply for these admissions |                       |
|                | *Dental hospitalisation for:*  
- Accident and injury | - Authorisation required | - Unlimited 100% of Scheme Rate  
- If admitted to a hospital or day-case facility:  
  - A deductible of R3 650 (hospital) or R2 400 (day-case facility) to be paid on admission  
  - If aged 12 years or younger: Deductible of R1 450 (hospital) or R700 (day-case facility)  
  - All dental devices, appliances, prostheses and orthodontics (surgical and non-surgical) are paid from the Acute Benefit at the Scheme Rate, subject to the dental appliances limit. |                       |

**Important:**  
- Conservative dentistry is not covered for persons over the age of 12 years  
- Dental implants are excluded from the Trauma Benefit, even if performed in hospital  
- Orthognatic surgery is not covered.

- Authorisation required  
- Subject to the cover available in Phase 1  
- Limited to R7 700 a person in Phase 4, paid at 60% of the Scheme Rate (Enhanced Option only)  
- Once you have reached this limit, no further dental treatment will be paid, inclusive of dental appliances, as noted below.

| Acute          | Conservative treatment – fillings, extractions, x-rays  
- Age 12 and under: May be paid from Trauma Benefit if applied for and approved  
- Over 12 years of age: Conservative dentistry performed in hospital will not be covered from Trauma Benefit | - No authorisation required | - Subject to cover from available funds in Phase 1 | - Subject to cover from available funds in your Phases  
- Limited to R7 700 in Phase 4 at 60% |

- Dental devices, appliances, prostheses and orthodontics (surgical and non-surgical)  
- Annual limit of R19 200 for each person  
- Subject to the cover available in the Phase you are in  
- Limit applies regardless of place of service  
- If the dentistry limit of R7 700 is depleted, no further dental treatment will be paid, inclusive of dental appliances, as noted above.

- Specialised dentistry | - Subject to cover from available funds in Phase 1 | - Subject to cover from available funds in your Phases  
- Limited to R7 700 in Phase 4 at 60% |

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* Dentistry is pro-rated. This means that if you join the medical scheme after January, you won’t get the full limit because it will be calculated by counting the remaining months in the year.

** Orthodontics are funded from the Acute Benefit in all instances and the appliances used in the treatment accumulate to the Dental Appliances Limit. Orthodontic treatment is not covered for patients aged 21 years and older. Orthognatic surgery, sometimes prescribed with orthodontic treatment, is not covered.
### General practitioners and specialists

<table>
<thead>
<tr>
<th>Classification</th>
<th>Benefit category</th>
<th>Requirement</th>
<th>Basic Option</th>
<th>Enhanced Option</th>
</tr>
</thead>
</table>
| **Acute** | Visits and consultations out of hospital (non-network GP and specialist) | - Super antibiotic injections require authorisation when not administered in hospital  
- Where consultations relate to hospitalisation (six weeks pre- and post), you may apply to reallocate claims to the Trauma Benefit  
- Please contact the call centre to get this application form | - Subject to the cover available in Phase 1 | - Subject to the cover available in phase you are in |
| Network GPs | Network GP consultation code funded from the Acute Benefit | - Subject to the cover available in Phase 1  
- After Phase 1 is exhausted, the Scheme pays for:  
  - Single member: R18 600  
  - Two consultations: R21 850  
  - For the family: R25 400  
  - Four consultations: R28 950 | - Subject to the cover available in phase you are in  
- During Phase 2, or if other phases exhausted, the Scheme funds unlimited network GP consultation codes |
| Network specialist | Specialist consultations and related procedures will be paid in full | - Subject to the cover available in Phase 1 | - Subject to the cover available in phase the member is in |

### Medicine

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</table>
| **Trauma** | Chronic medicine | - Available if your condition qualifies as a PMB  
- You have to register  
- If you choose not to use a formulary medicine, you may not claim more than the Chronic Drug Amount and you have to pay the difference yourself. | - Subject to formularies and Chronic Drug Amount  
- Formulary approved medicine is covered at 100% of the Scheme Medicine Rate |
| Acute | Prescribed medicine  
- Schedule 3 and up | - Limited to the cover available in Phase 1  
- Non-generic prescribed medicine will be paid at 100% of the Scheme Medicine Rate. | - Limited to funds available in the phase you are in  
- Annual sub-limits apply |
| Pharmacy-advised therapy or over-the-counter medicine  
- Schedule 0, 1 and 2 | - Limited to the cover available in Phase 1 | - Limited to funds in Phase 1  
- Does not accumulate to Phase 2, 3 or 4 |
| **Casualty** | Visits, consultations and procedures performed in casualty | - If you are admitted to hospital from casualty, claims will be paid from the Trauma Benefit. In this case, you need to call for authorisation  
- If you are not admitted to hospital from casualty, you do not need to pre-authorise | - Limited to the cover available in Phase 1  
- Facility fees are not paid by the Scheme | - Limited to funds available in the phase you are in  
- Facility fees are not paid by the Scheme |
### Eye care

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</thead>
<tbody>
<tr>
<td><strong>Trauma</strong></td>
<td>- Radial, keratotomy and excimer laser treatment</td>
<td>- Authorisation required</td>
<td>- No benefit</td>
<td>- Deductible of R2 500 for each eye - Limited to R4 350 for each eye, with an overall yearly limit of R16 500 for the family</td>
</tr>
<tr>
<td><strong>Acute</strong></td>
<td>- Lenses, contact lenses and frames, and eye tests</td>
<td>- All optical treatment is paid from Phase 1, including contact lenses - Cost of lenses and frames subject to cover available in Phase 1</td>
<td>- All optical treatment is paid from Acute Benefit, including contact lenses - Cost of lenses and frames subject to cover available in the phase you are in - Annual limit of R3 250 per beneficiary, including contact lenses</td>
<td></td>
</tr>
</tbody>
</table>

### Professional services

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</thead>
<tbody>
<tr>
<td><strong>Trauma</strong></td>
<td>Treatment (combined with psychiatric treatment) for: - Alcoholism - Drug and chemical dependency</td>
<td>- Authorisation required</td>
<td>21 days per person each year at a Designated Service Provider</td>
<td>- R18 500 for the family for the year - Hearing aids may be claimed once every two years - Wheelchairs may be claimed once every three years</td>
</tr>
<tr>
<td><strong>Medical appliances and hearing aids</strong></td>
<td>- Authorisation required</td>
<td>- R10 000 for the family for the year - Hearing aids may be claimed once every two years - Wheelchairs may be claimed once every three years</td>
<td>- Upon application - If granted, unlimited benefits through the Allied, Therapeutic and Psychology Extender Benefit</td>
<td></td>
</tr>
<tr>
<td><strong>Allied, Therapeutic and Psychology Extender Benefit</strong></td>
<td>- Clinical entry criteria applies - Upon application</td>
<td>- Not available</td>
<td>- Upon application - If granted, unlimited benefits through the Allied, Therapeutic and Psychology Extender Benefit</td>
<td></td>
</tr>
<tr>
<td><strong>Acute</strong></td>
<td>Allied, Therapeutic and Psychology Benefit: - Acousticians - Chiropractors - Counsellors - Dietitians - Homeopaths - Nurses - Occupational therapists - Physiotherapists - Podiatrists - Psychologists - Psychometrists - Social workers - Speech and hearing therapists - Chiropractors</td>
<td>- Limited to the cover available in Phase 1</td>
<td>- Limited to funds available in the phase you are in - Annual sub-limits apply M R11 000 M+1 R14 850 M+2 R18 150 M+3+ R21 000</td>
<td></td>
</tr>
</tbody>
</table>

### Auxillary services

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed care</strong></td>
<td>- HIV and AIDS - Diabetes - Oncology</td>
<td>- Registration on the relevant programme - Have to use the Scheme’s Designated Service Provider</td>
<td>- Unlimited - Subject to Prescribed Minimum Benefit</td>
<td>- Unlimited - Subject to Prescribed Minimum Benefit</td>
</tr>
</tbody>
</table>
Our reimbursement rules

- The **Scheme Rate** is the rate Altron Medical Aid has set for repaying claims. Altron Medical Aid adopted the Discovery Health Rate as the Scheme Rate.
- The **Scheme Medicine Rate** is the single exit price for medicine, plus the relevant dispensing fee.
- All service providers must be registered with the Medical and Dental Council, and have a valid practice number.
- Benefits are paid at Scheme Rates and are subject to sub-limits, where applicable.
- If the claimed amount is lower than the Scheme Rate, we will pay and accumulate the claimed amount.
- Healthcare professional claims that are charged at or lower than the Scheme Rate are paid directly to the provider. If the provider charges more than the Scheme Rate, the claim will be paid to you and you will need to settle the account with the provider.

Refund of Savings Account balances

If you ever have to end your membership of the Scheme, the balance in your Savings Account will be reimbursed in one of two ways:

- If you move to another medical scheme where your new health plan has a savings element, we will transfer the balance in your Savings Account to that medical scheme.
- If you join a medical scheme where your new health plan does not have a savings option, we will repay the balance directly to you.

However, if you owe anything to Altron Medical Aid by the time your membership ends, we will deduct the amount you owe from your Savings Account’s balance. We will transfer or pay the remaining funds to you about five months after your membership has ended.

Programmes to manage your health

We have programmes to help you manage three serious illnesses:

**Oncology Programme**

The Oncology Programme follows the South African Oncology Consortium guidelines so that cancer patients get access to the most appropriate level of treatment for the particular stage of disease. We assign a personal case manager who coordinates each member’s oncology benefits with his or her treating doctor. We pay most claims related to treating cancer from the Trauma Benefit, although we pay some from the Acute Benefit.

To register on this programme, please call 0860 100 417.

**Diabetes Programme**

The Diabetes Programme is offered by the Centre for Diabetes and Endocrinology. This programme is available to diabetics, who can benefit from a multidisciplinary approach to managing diabetes. The team consists of diabetic specialists, diabetic educators, dietitians, podiatrists, a resident clinical psychologist and an exercise specialist.

To access this benefit, please complete a Chronic Illness Benefit application form and send it to us for review. Once registered on the Chronic Illness Benefit for diabetes, you can register with the Centre for Diabetes and Endocrinology by calling 011 712 6000.

**HIV Care Programme**

Members registered on this programme can be sure of utmost confidentiality. The HIV Care Programme brings comprehensive disease management to our members who are living with HIV or AIDS. They will have access to unlimited hospitalisation and antiretroviral treatment, subject to our medicine list and the Chronic Drug Amount.

To register on this programme, please call 0860 100 417.
**Summary of exclusions**

Altron Medical Aid will not pay claims that are considered by the Scheme to be caused directly or indirectly by, or relate to, the following:

1. Healthcare services of a cosmetic nature, like otoplasty for bat ears
2. Healthcare services relating to port wine stains and blepharoplasty (eyelid surgery)
3. Healthcare services relating to obesity
4. Healthcare services relating to frail care
5. Healthcare services relating to infertility
6. Healthcare services relating to injuries sustained during participation in a wilful and material violation of the law
7. Healthcare services relating to injuries sustained during wilful participation in war, terrorist activity, riot, civil commotion, rebellion or insurrection
8. Experimental, unproven or unregistered treatment or practices
9. Healthcare services related to any waiting periods, if applicable
10. Healthcare services in respect of, or relating to, any complication that may arise from any exclusion
11. All costs related to bodily injury, illness or death while, or as a result of, participating in high-risk activities
12. All costs related to bodily injury, illness or death while, or as a result of, participating in any sports as a professional participant
13. All costs for which a third party is responsible
14. All biokinetic treatment

For more information about these exclusions, please visit our website at www.altronmedicalaid.co.za

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**Important tips**

**When claiming**

When claiming your medical expenses from Altron Medical Aid, whether for trauma, chronic or acute, please follow these steps:

- Send in your claims within four months from the date of service. Accounts older than four months expire, after which we won’t pay them.
- When sending in claims, please make sure the following details are clearly printed or written on the account:
  1. Your Altron Medical Aid membership number
  2. The service date
  3. Your doctor’s details and practice number
  4. The amounts charged
  5. The relevant consultation, procedure or NAPPI code and diagnostic (ICD-10) codes
  6. The name and birth date of the member or dependant who received the service
  7. If you have already paid for it, attach your receipt or make sure the claim shows ‘paid’.
- Remember to always keep copies of your claims.
- To see the progress of your claim, you can log in to www.altronmedicalaid.co.za

**Where to send your claims**

- Post your claims to PO Box 652509, Benmore 2010; or
- Fax your claims to 0860 329 252; or
- Email your claims to claims@discovery.co.za